Dallas
Glenn A. Tobleman, F.S.A., F.C.A.S.
S. Scott Gibson, F.S.A.
Cabe W. Chadick, F.S.A.
Michael A. Mayberry, F.S.A.
David M. Dillon, F.S.A.
Gregory S. Wilson, F.C.A.S.
Steven D. Bryson, F.S.A.
Bonnie S. Albritton, F.S.A.
Brian D. Rankin, F.S.A.
Wesley R. Campbell, F.C.A.S., F.S.A.
Jacqueline B. Lee, F.S.A.
Brian C. Stentz, A.S.A.
Robert E. Gove, A.S.A.
J. Finn Knox-Seith, A.S.A.
Jennifer M. Allen, A.S.A.
Josh A. Hammerquist, A.S.A.
Xiaoxiao (Lisa) Jiang, A.S.A.
Sujaritha Tansen, A.S.A.
Jay W. Fuller, A.S.A.
Sergei Mordovin, A.S.A.
Robert B. Thomas, Jr., F.S.A., C.F.A. (Of Counsel)

Actuaries & Consultants

Kansas City
Gary L. Rose, F.S.A.
Terry M. Long, F.S.A.
Leon L. Langlitz, F.S.A.
Anthony G. Proulx, F.S.A.
Thomas L. Handley, F.S.A.
D. Patrick Glenn, A.S.A., A.C.A.S.
Christopher H. Davis, F.S.A.
Karen E. Elsom, F.S.A.
Jill J. Humes, F.S.A.
Christopher J. Merkel, F.S.A.
Kimberly S. Shores, F.S.A.
Jan E. DeClue, A.S.A.
Patricia A. Peebles, A.S.A.

London / Kansas City
Roger K. Annin, F.S.A.
Timothy A. DeMars, F.S.A.
Scott E. Morrow, F.S.A.

Baltimore
David A. Palmer, C.F.E.

September 27, 2015

Green Mountain Care Board
State of Vermont
89 Main Street, Third Floor, City Center
Montpelier, VT 05620

Re: 1Q16 – 2Q16 MVPHIC Grandfathered Small Group EPO/PPO Rates
SERFF #: MVPH-130186136

The purpose of this letter is to provide a summary and recommendation regarding the proposed small group filing submitted by MVP Health Insurance Company (MVPHIC) for its grandfathered high deductible EPO/PPO products for the first and second quarters of 2016 and to assist the Board in assessing whether to approve, modify, or disapprove the request.

Filing Description

1. This filing demonstrates the premium rate development of MVPHIC's small group grandfathered EPO/PPO product portfolio comprising high deductible health plans (HDHP) and includes proposed rates for both the first and second quarters of 2016. Small groups who hold grandfathered products have coverage issued prior to March 23, 2010 and have not had substantial changes to their benefits.

2. This is a closed block of business. As of June 2015, there were 2,107 members enrolled in the plans impacted by this rate filing. Of those 2,107 members, 1,381 members have a first quarter effective date, and 265 members have a second quarter effective date.

3. This rate filing is requesting a quarterly rate change of:

Quarterly Rate Change			
	Small Group PPO/EPO	**1Q16**	**2Q16**
HDHP	Medical + Rx	-2.6%	1.1%

The requested quarterly rate increases, seen above, would result in the following annual rate changes for

1st quarter group renewals and 2nd quarter group renewals, when combined with prior approved filings:

Annual Rate Change								
	Small Group PPO/EPO	**2Q15**	**3Q15**	**4Q15**	**1Q16**	**2Q16**	**Annual 1Q16**	**Annual 2Q16**
HDHP	Medical + Rx	1.5%	2.2%	1.7%	-2.6%	1.1%	2.7%	2.3%

Standard of Review

Pursuant to Green Mountain Care Board (Board) Rule 2.000 Health Insurance Rate Review, this letter is to assist the Board in determining whether the requested rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the law, and is not excessive, inadequate, or unfairly discriminatory.

Summary of the Data Received

MVPHIC provided the methodology used in premium rate development (Exhibit 3) and details pertinent to its actuarial assumptions/experience driving the rate change request. This includes supplemental exhibits comprising historical claim and membership summary for 36 months grouped into rolling 12 month periods, pricing trend assumptions (Exhibit 2), conversion factor and tier ratios (Exhibit 4), retention expenses (Exhibit 5), and additional supporting exhibits as requested during review of the filing.

Company's Analysis

1. *HDHP Rate Development:* MVPHIC utilized grandfathered small group HDHP claim data for the period from January 1, 2014 through December 31, 2014 and paid through April 30, 2015 as the base period experience.

   Exhibit 3 illustrates both the claim projection from the experience period to the rating period and also the accompanying adjustments applied in deriving the rates for 1Q16.

   From the historical experience, claims in excess of $100,000 were replaced with a pooling charge. The pooling charge reflects the average cost of claims in excess of $100,000 and is based on historical experience. The run out for the experience period is four months.

   The adjusted claims were projected forward to the midpoint of the 1Q16 rating period using an annual paid medical trend assumption of 4.6% (elaborated further in item 2 below). The paid medical trend is derived from the proposed allowed cost trend rates and the impact of cost share leveraging[1]. The prescription claims were projected forward to the midpoint of 1Q16 rating period using an annual paid Rx trend of 17.9% (elaborated further in item 3 below).

   The trended claim cost was further increased to reflect fees and surcharges representing 1.2% of expected claims, retention expenses of 10.3% (constituting general administrative expense of 8.0% and contribution to surplus of 2.0%), premium taxes of 2.0%, ACA Insurer tax of 2.0%, VT vaccine pilot charge of 0.6%, transitional reinsurance fee of $2.25 PMPM for 2016 and $0.00 PMPM for 2017, and Patient-Centered Outcomes Research Institute (PCORI) Fee of $0.17 PMPM.

   The proposed expected claim liability PMPM was also adjusted for the single conversion factor[2] change

[1] Leveraging is the result of the fixed nature of deductibles and copays causing the carrier to bear a greater portion of the cost of the medical inflation

[2] The conversion factor adjusts premium that is developed on a PMPM basis to be on a tiered (single, double, parent/children, family) basis. This adjustment is necessary because the premium on a PMPM basis is an average over all adults and children. However, the tiered premiums require the base premium to be for a single adult.

(derived using January 2014 – December 2014 membership distribution) to derive the gross claim cost for 1Q16. The required premium revenue PMPM for 1Q16 was compared to the 4Q15 premium rates for the membership underlying the experience period to determine the required quarterly rate change of -2.6%.

MVPHIC developed the 2Q16 premium by applying one more quarter of trend to the experience period claims resulting in required quarterly rate change of 1.1%.

2. *Medical Trend:* The assumed unit cost trends reflect a combination of known and assumed price increases from MVPHIC's provider network. Consistent with recently submitted filings, MVPHIC is utilizing a 0% utilization trend to its data. MVPHIC opines that based on regression analysis of its utilization data in the past, the predictive ability of the historical utilization trends was weak and not reliable.

   The table below illustrates the trend factors for various benefit categories:

Annual Allowed Cost Trend		
Service Category	**2015**	**2016**
Inpatient	5.4%	5.5%
Outpatient & Other Medical	4.8%	4.6%
Physician	2.9%	0.0%
Total Medical Trend	**4.4%**	**3.4%**

   The allowed cost trends illustrated above are based on allowed charges (reflecting total amount of claims paid by the carrier and the policyholder) and do not reflect effective paid trends, which reflect the actual claim payment by carrier only. MVPHIC adjusted the allowed cost trends illustrated above to account for the impact of cost share leveraging and derived the annual effective paid medical trend factor of 4.6% from 2014 to 2016, as indicated in item 1 above. This effective paid trend factor is used to trend the claim costs from the experience period to the rating period in calculating the projected claim cost for the rating period. For this filing, two years of the 4.6% trend were used to trend the experience period claims forward.

3. *Rx Trend:* MVPHIC is requesting the annual allowed trends illustrated in the chart below:

Annual Rx Allowed Cost Trend	
2015	**2016**
8.9%	16.1%

   The annualized effective paid trend derived from the requested allowed trends in the chart above is 17.9%, which blends the allowed trends to get to the projection period and accounts for cost sharing by the insured (through the use of deductible, copay and coinsurance).

   MVPHIC analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVPHIC's pharmacy vendor and did not account for MVPHIC's Vermont specific book of business, given the partnership with this vendor is new.

4. *Administrative Expenses:* As in the prior approved filing, projected taxes, assessments and retention are added to projected net claims to develop the gross cost for 2016. The retention charges include 8.0% of premium for general administrative expense. This is a reduction of 1.5% from the 3Q/4Q15 filing. There is also an assumption of 2.0% for contribution to surplus and other miscellaneous charges similar to the 3Q/4Q15 filing, such as the ACA Insurer fee and VT Paid Claim Tax.

L&E Analysis

1. *Rate Development:* During our analysis of MVPHIC's rate development methodology, we reviewed the assumptions and adjustments made to the experience data set for large claims and expense loads. We also reviewed the projected loss ratios and how these amounts compared to the company's historical experience.

   We note that MVPHIC's loss ratio for the small group market in the experience period (January 2014 – December 2014) exceeded the minimum loss ratio requirement of 80%. The unadjusted medical loss ratio for the grandfathered group for the experience period is 91.8%.

   MVPHIC's 2015 anticipated traditional loss ratio and federal medical loss ratio (which adjusts the loss ratio for quality improvement expenses and taxes) for this grandfathered block, as illustrated below, exceed the minimum loss ratio requirement.

Projected MLR	
Projection Period	**Traditional Loss Ratio**
1Q 2016	83.8%

   The assumed administrative load of 8.0% of premium is lower than what was assumed in the prior 3Q/4Q 2015 filing. We assessed that MVPHIC's assumed general administrative load to be lower than the actual expense ratio for the small group products, as illustrated in the Supplemental Health Care Exhibits:

Administrative Expense Summary for Small Group Products				
	Member Months	Premium PMPM	Admin PMPM	Expense Ratio
2010	186,297	$344.28	$39.71	11.5%
2011	209,126	$348.79	$34.17	9.8%
2012	190,795	$365.29	$37.24	10.2%
2013	178,794	$394.67	$46.56	11.8%
2014	64,143	$411.16	$33.39	8.1%

   If MVPHIC's envisioned strategy to reduce its administrate expenses does not materialize, future rate increases could be higher than anticipated.

   We note that MVPHIC did not adjust the experience period for anticipated changes in demographics (age and gender) and utilized experience period contract distribution to calculate the 2016 single conversion factor. Considering the shift in membership of this closed block, we believe that it is more appropriate to use the most recently available demographic and contract distribution in projecting the anticipated rate change and the single conversion factor. The demographic factor from the experience period of 1.550 increased to 1.562 for June 2015. Please note as a result of this recommendation, the calculation of the single contract conversion factor should also be modified.

   If the contract distribution from June 2015 was used instead of the experience period, the single conversion factor would increase from the experience period factor of 1.208 to the June 2015 factor of 1.212, which is an increase of 0.3%. The combination of the demographic adjustment and the revised contract conversion factor will increase the recommended 1Q quarterly rate change by 1.1%.

   We find all other adjustments to the projected claim costs to include benefit mandates, taxes, and ACA related costs to be reasonable and appropriate.

With the recommended changes to the demographic assumption in the rate change calculation and single conversion factor calculation, MVPHIC's rate development methodology appears to be reasonable and appropriate.

2. *Medical Trend:* The total effective paid medical trend factor of 4.6% assumed is this filing represents updated information since the 2016 Exchange filing. In particular, there is more run-out in the underlying claims data, and MVP has negotiated new provider contracts since the Exchange filing. In a confidential response to an inquiry, MVPHIC provided a comparison of the assumptions underlying the 2016 Exchange filing trend assumptions and the 1Q2016 small group grandfathered filing trend assumptions. This filing reflects slightly higher inpatient trends and slightly lower outpatient trends than the assumptions seen in the Exchange filing. The net impact of these changes from the Exchange filing is less than 0.1%.

   We consider the development of 2016 medical trend using negotiated unit cost change with providers and GMCB approved rate changes to be reasonable and appropriate. We consider the annual medical paid trend assumption of 4.6% to be reasonable and appropriate.

   Given that MVPHIC is assuming a 0% utilization trend, we note that if higher utilization is actually materialized in the rating period, then future rate increases could be higher than anticipated.

3. *Rx Trend:* MVPHIC analyzes its pharmacy data by drug category (Generic, Brand, Specialty). Annual trend factors by drug category were supplied by MVPHIC's pharmacy vendor and did not account for MVPHIC's Vermont specific book of business, given the partnership with this vendor is new. We consider MVPHIC's approach of using Rx trends from its vendor without accounting for its Vermont specific block of business to be a limitation on the reasonableness of their proposed Rx trend assumption.

   MVPHIC's rationale for using unadjusted trends includes the following:
   - The new PBM (contracted on January 1, 2015) does not have enough MVPHIC data to provide a credible Rx trend forecast based on MVPHIC's experience.
   - The historical trends do not reflect the constantly changing Rx market and do not account for drugs coming off patent, changes in average wholesale price, new drugs being released to the market, and price competitiveness amongst generic and brand drug manufacturers. This includes new drugs like PCSK-9 Inhibitors that have been approved for use recently and would not be reflected by the company's historical experience.

   The Rx trends used in this filing are materially higher than those in the recently approved Exchange filing. Both estimates are taken from forecasts provided by MVPHIC's PBM. For the Exchange filing, MVPHIC used the "Low Estimate" from the PBM, whereas MVPHIC has proposed using the "Best Estimate" for this filing. In response to an inquiry, MVPHIC provided insufficient justification for modifying the trend assumptions between these two filings. We recommend that the requested trend assumptions be reduced to reflect the approved trend that was assumed for Exchange products. The two

sets of trend assumptions are summarized in the table below[3]. This change would result in a decrease in the requested 1Q16 rate change of -0.3% and decrease in the requested 2Q16 rate change of -0.1%.

	2016 Trend in Exchange Filing			2016 Trend Proposed in SG GF Filing		
	Unit Cost	Utilization	Total Trend	Unit Cost	Utilization	Total Trend
Generic	3.3%	2.1%	5.5%	4.2%	3.0%	7.3%
Brand	13.5%	-4.5%	8.4%	14.0%	-2.8%	10.8%
Specialty	14.0%	6.0%	20.8%	17.0%	7.0%	25.2%

4. *Administrative Expenses:* We assessed that MVPHIC's assumed general administrative load of 8.0% to be lower than the actual expense of 8.5% for all markets as illustrated in MVPHIC's 2014 Supplemental Health Care Exhibit. If MVPHIC's envisioned strategy to reduce its administrative expenses does not materialize, future rate increases could be higher than anticipated.

   The proposed contribution to surplus is 2.0%. In the last two orders, the Board has reduced the proposed contribution to surplus from 2.0% to 1.0%. We recommend that the solvency analysis performed by DFR be considered when making changes to this assumption.

   We find the administrative assumptions to be reasonable and appropriate.

[3] The total allowed Rx trend is calculated by taking the weighted average of the total trends for each tier by the experience period distribution of allowed costs. Because this distribution by tier differs for each block, even the same trend assumptions will yield different final allowed trends.

Recommendation

After modifications, L&E believes that this filing does not produce rates that are excessive, inadequate, or unfairly discriminatory. Therefore, L&E recommends that the Board make the following modifications:

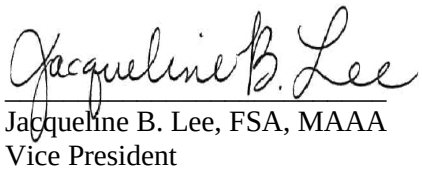
- Reflect updated enrollment by age and tier in the rate change development and the single conversion factor calculation. This modification would add 1.1% to 1Q16 rate change.
- Modify the Rx trend assumptions to reflect the "Low Estimate" from the PBM, as MVPHIC chose this as an appropriate assumption for the recently approved Exchange filing. This modification would subtract 0.3% from 1Q16 rate change and 0.1% from 2Q16 rate change.

The above changes will increase the 1Q16 quarterly rate change from -2.6% to -1.9%, and decrease the 2Q16 quarterly rate change from 1.1% to 1.0%.

Modified Quarterly Rate Change			
	Small Group PPO/EPO	**1Q16**	**2Q16**
HDHP	Medical + Rx	-1.9%	1.0%

Modified Annual Rate Change			
	Small Group PPO/EPO	**1Q16**	**2Q16**
HDHP	Medical + Rx	3.5%	3.0%

Sincerely,



Jacqueline B. Lee, FSA, MAAA
Vice President
Lewis & Ellis, Inc.

David M. Dillon, FSA, MAAA, MS
Vice President & Principal
Lewis & Ellis, Inc.

ASOP 41 Disclosures
The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations[4], promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct[5], to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary
The responsible actuaries are:

- Jacqueline B. Lee, FSA, MAAA, Vice President at Lewis & Ellis, Inc. (L&E).
- David M. Dillon, FSA, MAAA, MS, Vice President & Principal at Lewis & Ellis, Inc. (L&E).

These actuaries are available to provide supplementary information and explanation. The actuaries also acknowledge that they may be acting as an advocate.

Identification of Actuarial Documents
The date of this document is September 27, 2015. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is September 25, 2015.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Green Mountain Care Board. The authors of this report are aware that it will be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the health insurance issuers whose rate filings were reviewed. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Board in assessing whether to approve, modify, or disapprove the rate filing.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- Lewis & Ellis has reviewed the data provided by the issuers for reasonableness, but we have not audited it. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- We are not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.
- The findings of this report are enclosed herein.

Actuarial Findings
The actuarial findings of the report can be found in the body of this report.

[4] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

[5] These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

Methods, Procedures, Assumptions, and Data
The methods, procedures, assumptions and data used by the actuary can be found in body of this report.

Assumptions or Methods Prescribed by Law
This report was prepared as prescribed by applicable law, statues, regulations and other legally binding authority.

Responsibility for Assumptions and Methods
The actuaries do not disclaim responsibility for material assumptions or methods.

Deviation from the Guidance of an ASOP
The actuaries have not deviated materially from the guidance set forth in an applicable ASOP.